**Print in Color or Grayscale Only**
Using Adobe Acrobat Reader 8.0 or later

# Review of Systems

Please answer every question

## Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

**Please mark only the symptoms you CURRENTLY are experiencing.**

**Mark all that apply ---- if no symptoms, please mark "NONE"**

| | | | | |
|---|---|---|---|---|
| **General** | | weight loss | fever | |
| | fatigue | weight gain | persistent infections | **NONE** |
| **Eyes** | | visual disturbances | glasses / contacts | **NONE** |
| **Ear, Nose, and Throat** | | hearing aids | dentures / partial | |
| | difficulty swallowing | hearing loss | sinus pain | |
| | difficulty breathing through nose | seasonal allergies | oral ulcers | **NONE** |
| **Cardiovascular** | | palpitations | difficulty breathing on exertions | |
| | chest pain | shortness of breath | swelling hands/feet | **NONE** |
| **Respiratory** | sleep apnea | difficulty breathing | chronic cough | |
| | oxygen use | wheezing | coughing blood | **NONE** |
| **Breast** | mass/lump | breast pain | nipple discharge | **NONE** |
| **Gastrointestinal** | | appetite changes | indigestion | |
| | nausea | constipation | bloody stool | |
| | vomiting | chronic diarrhea | hemorrhoids | |
| | change in bowel habits | abdominal pain | excessive gas | **NONE** |
| **Female Genitourinary (Women Only)** | | | blood in urine | |
| | pelvic pain | vaginal dryness | painful urination | |
| | urinary frequency | vaginal discharge | painful menstruation | |
| | urinary urgency | vaginal itch or burning | menstrual irregularities | |
| | excessive urination at night | painful intercourse | urine leakage | **NONE** |
| **Male Genitourinary (Men Only)** | | | | |
| | urine leakage | urinary frequency | testicular mass | |
| | painful urination | urinary urgency | testicular pain | |
| | change in urinary stream | impotence | penile lesions | |
| | excessive urination at night | urethral discharge | blood in urine | **NONE** |
| **Musculoskeletal** | | stiffness | finger trigger / catch | |
| | joint pain | muscle pain | muscle weakness | **NONE** |
| **Skin** | | | change in lesion | |
| | dry skin | rash | new sore/lesion | |
| | change in wart or mole | hives | skin ulcer | **NONE** |
| **Neurologic** | | decreased sensation | tremors | |
| | fainting | numbness | seizures | |
| | decreased memory | trouble walking | headaches | **NONE** |
| **Psychiatric** | | frequent crying | anxiety | |
| | change in sleep pattern | depression | fearful | **NONE** |
| **Endocrine** | | heat intolerance | cold intolerance | |
| | hair changes | excess thirst | hot flashes | **NONE** |
| **Heme/Lymphatic** | | | | |
| | easy bruising | excessive bleeding | gland problems | **NONE** |
| **Vascular** | | | swelling / edema hands, arms, legs, feet | |
| | cool / cold fingers | bleeding veins | cramping / pain in legs at rest | |
| | varicose veins | cool / cold toes / foot | pain in calves when walking | **NONE** |

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SAMPLE

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